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UNIVERSITY OF ALBERTA

ADOLESCENT CHILDREN OF ALCOHOLICS: PERSONALITY PROFILES

BY

SHERRY M. GREENBANK

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF:

MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled ADOLESCENT CHILDREN OF ALCOHOLICS: PERSONALITY PROFILES submitted by SHERRY M. GREENBANK in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION in COUNSELLING.

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ABSTRACT

This study examined the personality characteristics of a sample of adolescent children of alcoholics, aged 12 to 17, from the perspective of parents and of the teens themselves. Fifteen parent-child dyads completed the Personality Inventory for Children (completed by parents) and the Basic Personality Inventory (completed by child). Questionnaires were hand-scored and results compared to appropriate norms. T-scores were charted and frequencies for each subscale were tabulated.

Consistent with previous reports of psychosocial difficulties among the COA population, parent responses on the PIC suggested that many of their children may have personality characteristics significantly different from the general population. However, adolescents' responses on the BPI, as a group, tended to be within the average range. When subscale scores were compared to those found in the general population, adolescent children of alcoholics were found to be overrepresented at the clinical range (T>70). Depression was consistently present among elevated scores on both the PIC and BPI. However, there was a wide range of individual scores in the sample, lending some support to the contention that COAs are a heterogeneous population.

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CHAPTER I

Introduction

Background to the Problem

In recent years, focus appears to be moving from the adverse effects of drinking on the abuser alone, to include a wider range of consequences to the persons with whom the alcoholic surrounds him/herself. There are, however, very few empirical studies which look at the effects of parental alcoholism on the emotional functioning of children. As in other areas, methodological problems such as the use of small, undefined samples, make a large proportion of this work difficult to interpret. Most commonly, attempts to characterize children of alcoholics are based solely on clinical observation (e.g. Black, Bucky & Wilder-Padilla, 1986; Woititz, 1983) directed toward counselors or intended for self-help and exploration (e.g. Ackerman, 1987; Deutch, 1982). Comparatively little empirical evidence is available at present.

Many studies indicate definite detrimental effects associated with growing up in an alcoholic home, including: school and social problems (Chafetz, 1979), lowered self-esteem (Baraga, 1978), role confusion (Nardi, 1981) and suicidal tendencies (el Guebaly & Offord, 1977), as well as an increased risk for alcoholism (Cotton, 1979). In fact, some writers in the area suggest that in spite of an

appearance of 'survival', all children are nonetheless affected by the alcoholic environment (Black & Brown, 1979). A "recognizable pattern of interpersonal discomfort and intrapsychic conflict" is proposed (Black et al, 1986). Woititz (1983) contends that the main problem with current research is that we have not yet 'labeled' this population fully (p.3). However, other researchers suggest that the major issue with regard to children of alcoholics is not the lack of a label, it is the way the label is used (Beidler, 1989). Beidler (1989) contends that there is not sufficient evidence available to posit a clearly defined and unique syndrome labeled 'Children of Alcoholics'. Thus, movement away from labeling of individuals toward the study of the differential impact of family alcoholism is suggested.

In a recent study examining personality characteristics of children of alcoholics, as reported by the alcoholic parents on the Personality Inventory for Children (PIC), several significant findings were reported (Kostyniuk, 1988). Most notable is the prominence of depression, suggesting "the presence of this trait or factor as a central feature of the personality variables of children of alcoholics" (p.42). Another interesting finding pertained to the Family Relations scale; the percentage of children of alcoholics scoring in the clinical range surpassed normal statistical expectations tenfold. However, it is contended that although 10 percent of the sample attained scores in

the clinical range, 90 percent of the ratings remained within the normal range (ie. T score < 60). This result, in conjunction with the finding that extreme scores were concentrated on only four of the fourteen PIC scales, supports a cautionary approach to labeling. Children of alcoholics may display fewer personality difficulties than has been suggested in the past.

Purpose of the Study

The purpose of the present study is to build upon the earlier research efforts by Kostyniuk (1988), extending the exploration to include a direct investigation of the children's as well as their parent's perceptions of the child's emotional functioning. This is an important consideration, as the Personality Inventory for Children relies on parent responses to determine the emotional functioning of their children. An investigation of children's self-reported personality functioning along with parental perceptions may provide a richer data base from which to draw conclusions about the personalities of children of alcoholics. Further, directly exploring the children's own perceptions may yield important objective and empirical information for clinicians and researchers working in the areas of addiction and personality.

Limitations and Implications

Although the present study attempts to represent the perspective of both parents and children, some caution must be exercised in interpreting the results. Of particular importance is the fact that all parents are members of a self-help group, and as such may demonstrate a systematically different response set than parents who are not receiving any support or assistance with issues associated with alcoholism. This may also be reflected in the adjustment of the adolescents themselves. Thus, it is uncertain whether the responses offered by the sample may be generalized to the total population of adolescent children of alcoholics.

A further factor influencing the generalizability of the research findings is the relatively small sample size. Although a large pool of potential participants was contacted and many parents expressed an interest in the findings, comparatively few parents agreed to approach their teenagers about participation. The resulting low response rate may be a function of the sensitive nature of the research topic. As one anonymous respondent commented, "you have undertaken the task of trying to bring shy forest creatures out into the light".

Further caution must be taken in making causal conclusions on the basis of ex post facto data, particularly to assume that parental alcoholism is the sole cause or

explanation of the children's personality functioning. As Clair and Genest (1987) report, a number of potential moderator variables may play a role in the overall adjustment of children of alcoholics. Due to the length of the PIC and BPI and the lack of an appropriate reliable measure, moderating variables such as family environment factors and type of parental alcoholism were not directly assessed. However, some indication of these factors can be derived from responses to individual test items and scale scores (ie. the PIC's Family Relations scale).

Questions regarding personality characteristics of children of alcoholics have important practical implications. As research demonstrates that these children present with a tendency toward problems in the area of emotional and behavioral functioning, it is imperative that treatment address this issue. Moreover, if a particular trait is discovered to be an important variable characteristic of COAs, then practitioners may be in a better position to make informed placement decisions and meet the needs of this growing client population. If, on the other hand, as Beidler (1989) suggests, empirical evidence does not lend itself to the proposition of children of alcoholics as an identifiable group characterized by specific attributes, this is also valuable information for the clinician and researcher alike.

CHAPTER II

Impact of Parental Alcoholism

Recent American statistics conservatively estimate that from 9 to 13 million persons in the United States are alcoholics (Leikin, 1986). "For every alcohol misuser, five other persons suffer directly" (Paolino and McCrady, 1977, p.4); as many as four family members are affected (Leikin, 1986). By these estimates, 32 - 65 million Americans are touched by alcohol abuse. It is no wonder that concern and attention has recently been directed toward the possible problems associated with growing up in a household with an alcoholic parent. Children of alcoholics, who in the past were referred to as "the forgotten children" (Cork, 1969) and "a neglected problem", are now receiving widespread attention.

The issue has been made more visible with the advent of many self-help organizations (ie. AlaTeen), workshops, and therapeutic groups directed specifically toward this "proximal" population. A growing body of literature corroborating the negative effects of living with an alcoholic family member (ie. Cotton, 1979; Ackerman, 1987) have certainly contributed to this. If many persons are touched by alcoholism and the results of such an association are reported to be detrimental, then a trend toward therapy and help-seeking by these persons may be expected.

The earliest studies of children of alcoholics (COAs), focused primarily on the transmission of alcoholism by heredity rather than the psychosocial consequences for the family members (Chafetz, Blane & Hill, 1971). However, clinicians and researchers now recognize that there may also be important psychosocial consequences for children with an alcoholic parent. The purpose of this chapter is to highlight representative and current research that attempts to offer at least a partial explanation of intergenerational transmission of alcoholism, from a biological and family perspective. However, the primary focus will be upon the major themes and conclusions found in the literature regarding the psychosocial impact of parental alcoholism on children, and personality in particular.

Intergenerational Transmission

Genetic Markers

Marc Schuckit (1980) has defined a marker as "a measurable variation in structure, function or performance which is associated with an illness" (p.3). A genetic marker, then, should be under genetic control, be ideally observed in those carrying the illness, and be transmitted genetically within a family with a history of the illness. The marker does not necessarily 'cause' the illness (Russell, Henderson & Blume, 1986); it may simply serve as an indicator to identify persons maximally vulnerable to the development of the disorder. In fact, multiple markers may

exist for a single disorder. This appears to be the case in genetic vulnerability to alcoholism (Russell et al, 1986).

However, according to Propping (1987), not all individuals who possess the markers will actually develop alcoholism. Factors other than genetics may play an important role in whether or not alcoholism is displayed in the phenotype (Wolin, Bennett, Noonan & Teitelbaum, 1980). Thus, it is not a simple case of Mendelian genetics; alcoholism does not appear to be carried on a single gene. Based on a large body of clinical and epidemiological evidence, it is proposed that a complicated behavioral disorder like alcoholism, may better fit a multifactorial model of transmission (Russell et al, 1986, p.17).

A number of empirical studies have been conducted to establish a significant link between parental alcoholism and the drinking practices of their children (e.g. Bohman, Cloninger, Sigvardsson & von Knorring, 1987; Cotton, 1979; Midanik, 1983). In a review of the familial incidence of alcoholism, Cotton (1979) summarized 39 previous studies which included a total of 6,251 alcoholics and 4,083 nonalcoholic controls. A number of interesting results ensued: (1) 40-50% of alcoholics have a close relative who is an alcoholic, a significantly greater number than controls; (2) paternal alcoholism accounted for the greatest amount of reported familial alcoholism among the problem-drinkers (25%); (3) female alcoholics were more likely to

report a family history of alcoholism than were their male counterparts (ie. 50% of females vs. 30% of males reported having at least one alcoholic parent). The latter finding is extremely important, as the majority of research regarding genetic markers in alcoholism focuses on sons of alcoholic fathers (Schuckit, 1985).

The Stockholm Adoption Study, involving 862 men and 913 women, has been an ongoing and rich source of information about intergenerational alcoholism transmission since 1981 (Bohman et al, 1987). Among their findings are numerous indications regarding the possible genetic components of alcoholism. The following comprise only a small selection: (1) higher rates of alcohol abuse among individuals with a family history of alcoholism (23% vs. 14%); (2) no significant relationship between the adoptive parent and child's drinking patterns, which is contrary to the 'imitation of parental drinking' hypothesis; and (3) an identification of at least two distinct subtypes of alcoholic families. In general, Type I alcoholism or 'Milieu-limited' is associated with higher risk of alcoholism for both male and female children (p.449), specifically a 2:1 ratio as compared to controls. Type I is characterized by adult-onset and low criminality in both parent and child; it appears to require both heritability and negative environmental influence (ie. low SES, extended time in institution prior to child's adoption). On the

other hand, Type II transmission is 'Male-limited' (p.450) and regardless of the sons' postnatal environment, their risk of alcoholism was increased nine-fold. Male-limited transmission is characterized by teen onset, severe alcohol abuse requiring at least one hospitalization, and a serious criminal history (Bohman et al, 1987).

Attempts to identify biological markers associated with a predisposition toward alcoholism have been undertaken (e.g. Hill, Steinhauer, Park & Zubin, 1990; Schuckit, Gold, Croot, Finn & Polich, 1988; Schuckit, Risch & Gold, 1988). Areas that are receiving current attention include neurophysiology and genetically determined biochemical factors associated with alcohol tolerance (e.g. Hill et al, 1990; Schuckit, 1980).

It has been suggested that sons of alcoholics may be less susceptible to the intoxicating effects of ethanol (Schuckit, 1980). A series of subjective and cognitive psychomotor tests comparing the change in responses of males with and without an alcoholic family history after drinking equal amounts of ethanol, suggest that the former may have a predisposition to metabolize alcohol more quickly (Schuckit, 1980). Schuckit (1988) also reports that despite no baseline differences in ACTH, a hormone released by the pituitary gland in response to the central nervous system (Kalat, 1984), these levels are lower in sons of alcoholics two hours after drinking than in controls. He suggests that

this provides a partial explanation for his further finding that sons of alcoholics report less subjective feelings of intoxication while drinking and displayed lower overt impairment than control individuals at equal blood alcohol levels (Schuckit, 1988). Therefore, males with a history of family alcoholism appear to be physically capable of drinking greater amounts of alcohol, a trait which is associated with the development of alcoholism (McAuliffe & McAuliffe, 1975).

If alcohol has a different effect on the nervous tissue of sons of alcoholics, this may mediate the quality or intensity of the intoxication. A number of studies have addressed this possibility by examining individuals' brain electrical activity in response to auditory and visual stimuli. In the evoked potential method, considerable consistency in results have been obtained for the P300 component in individuals with a family history of alcoholism but who are not themselves alcoholic (Hill et al, 1990). The method commonly uses an "oddball paradigm" (Begleiter, Porjesz, Bihari & Kissin, 1984) where subjects are required to discriminate rare targets (ie. high pitched tones) from frequent non-targets (ie. low pitched tones). The predictability of targets is manipulated, for example, by instructing subjects that two targets never occur in succession. Throughout task performance, the electroencephalogram is recorded, identifying the amplitude

and latency of the P300 component. P300 is believed to be associated with information processing; the degree of latency in its appearance following the presentation of a stimulus may give an indication of attention and speed of processing (Kalat, 1984).

In a study of 'high density' family histories of alcoholism (individuals having first and second degree alcoholic relatives), Hill et al (1990) find that children in the third generation who are not themselves alcoholic display variations in P300 amplitude and latency as compared to children without such a history. This finding holds under conditions of minimal processing demands (ie. stimuli are highly predictable), but increasing the task demand resulted in a 'normalized' P300 amplitude (p.10). It is suggested that under minimal demands, greater time is required for 'high risk' children to complete a stimulus evaluation. However, when sufficient motivation is introduced, attention is more focused and the response is consequently altered (p.15). This implies that high risk children tend not to process information along a continuum for increased complexity. Instead, a large jump in processing activity is demonstrated when attention demands are increased. Hill et al (1990) predict that this characteristic may quickly take the child's processing level to its optimum and result in rapidly increasing deficits once this level of performance is exceeded.

The Hill et al study suggests that under certain conditions, individuals with a family history of alcoholism are either unwilling or unable to pay as much attention to their surroundings. Having screened out children displaying psychiatric family histories and neuropsychological dysfunctions, their results also lend support to the hypothesis that children of alcoholics tend to feel less intoxicated. Perhaps these individuals typically pay less attention to their internal and external cues of intoxication.

As provocative as the above findings may be, a note of caution must be voiced. Research experience utilizing evoked potentials (ERP's), and especially its P300 component, may still be in its infancy. As pointed out by Ray Johnson Jr. (in press), although great strides have been made over the past two decades in characterizing P300 amplitude and latency, a complete understanding of its relationship to cognitive activity remains elusive. He attributes a great deal of confusion to the many constructs that researchers have offered to account for P300 variations, including:

> attention, context updating, decision-making, equivocation, intentional engagement, orienting, processing demand, salience, task relevancy, uncertainty reduction, the utilization of a general purpose cortical process, and value (p.1).

Given this apparent uncertainty, the application of conclusions regarding the cognitive functioning of different

populations (ie. children of alcoholics) must remain hypothetical at best.

Family Transmission

Throughout the preceding discussion of biological markers, focus was placed upon differences between high risk individuals (family history positive) and control populations. However, many children of alcoholics do not become alcoholic themselves. It is therefore important to explore possible explanations accounting for this fact. What familial characteristics may contribute to or protect against vulnerability toward alcoholic transmission?

The influence of the family on its members drinking habits is certainly not a new discovery or topic for research, as evidenced by the following 1910 pre-prohibition observation:

> Family liquor drinking is first among the agencies that are influencing our boyhood's fatal choice. From the cellar and the sideboard of the home is borne to the family dining table the stimulating cup of which both young and old partake. (cited in Midanik, 1983)

However, clinical evidence is now available to confirm that some families are at a considerably greater risk of cross-generational transmission than others. The evidence from animal studies and physiological differences between humans (e.g. Schuckit, 1988) indicates a genetic influence on transmission, but does not rule out environmental factors.

The Family Systems perspective has been applied to provide an understanding of the variables associated with

family alcoholism (Ablon, 1974; Anderson & Henderson, 1985; Minuchin, 1974). It is proposed that the transmission of alcoholism from one generation to the next involves the whole family system over time (Steinglass, Bennett, Wolin & Reiss, 1987). The context of transmission is the sum total of interactions, beliefs, and attitudes that define the family. Therefore, the 'passing on' of alcoholism across generations is viewed as a process that is characterized as ongoing and dynamic. There is no crisis point or miraculous conversion necessary (Steinglass et al, 1987); whether or not history repeats itself depends on the role 'alcoholism' plays in the lives of the family unit throughout its development.

A recent study (Preli, Protinsky & Cross, 1990) comparing the structural variables of adaptability and cohesion as manifested by alcoholic, nonalcoholic, and recovered families has been conducted using the Family Adaptability and Cohesion Evaluation Scales (FACES III) (Olson, 1986). Adaptability is defined as the family system's ability to change its structure of power, roles, and rules in response to developmental and situational stress (Olson, Sprenkle & Russell, 1979). Cohesion refers to the "emotional bonding members have toward one another and the degree of individual autonomy a person experiences in the family system" (Olson et al, 1979, p.5). Scores at the scale's extremes indicate disengagement (very low) and

enmeshment (very high). Enmeshment is believed to preclude autonomy while disengagement precludes interdependence (Minuchin, 1974).

The findings generally support current thinking about alcoholism, proposing it is a 'family disease' systematically impacting upon all members (Bepko & Krestan, 1985). Analysis of variance indicates a higher incidence of extreme scores in cohesion among members of alcoholic families (Preli et al, 1990), confirming family systems theory which suggests dysfunctional families are more likely to experience problems with emotional bonding and individual autonomy (Minuchin, 1974). A higher incidence of rigid or chaotic patterns of adaptability is also significant among alcoholic families, suggesting either very low ability to change in response to stress, or excessive flexibility (very little evidence of stability or predictability).

Closely related to the structural characteristics of a family is its 'identity'; how does it define itself? According to Steinglass et al (1987), an important determinant of intergenerational transmission is the extent to which the family identifies itself as an 'Alcoholic Family'. A number of variables are suggested that reflect family identity: short-term problem-solving, daily routines, and family rituals (Steinglass et al, 1987). These variables are the overt regulating behaviors (Jackson, 1957); as homeostatic mechanisms they react to perceived

environmental threats to the stability of the family unit. However, as indicated by Preli et al (1990), the alcoholic family tends to either maintain the status quo despite requirements to change or it is too easily activated, reacting to the slightest change in the environment.

Family identity is comparable to a shared version of Jean Piaget's 'cognitive structure' (in Thomas, 1985). It is the underlying set of fundamental beliefs, attitudes, and attributions the family shares about itself (Steinglass et al, 1987). If one of the shared family beliefs is that alcohol is a central organizing principle for family life (an Alcoholic Family identity) then the continuance or discontinuance of this belief in the next generation will be a major determinant of whether alcoholism is transmitted across generations. Thus, a family dynasty can be built around alcohol in the same manner as it can around power or wealth. Given the critical nature of one's family identity, the ability to determine its contents is tremendously important. However, as is the case with an individual's underlying cognitive structure, family identity is typically outside conscious awareness (Steinglass et al, 1987). Therefore assessment of the more overt behaviors that reflect its nature is necessitated: problem-solving, daily routines, and family rituals. Of these behaviors, it has been hypothesized that family rituals contribute most powerfully to the family's identity (Steinglass et al, 1987)

and are therefore selected for closer study.

In a combined psychiatric and anthropological effort (Wolin, Bennett, Noonan & Teitelbaum, 1980) aspects of the psychosocial milieu of families in which alcohol problems have been experienced by both parents and offspring (transmitter families) and of families where these problems are confined to the parental generation (nontransmitter families) were examined. The results identified distinguishing characteristics of these two groups, lending some enlightenment to the question of why transmission takes place in some families but not in others.

The research of Wolin et al (1980) focuses on family rituals which are centred in the home, away from public scrutiny and the direct intervention of religious institutions. Rituals are a form of symbolic communication; they stabilize family life by clarifying roles, delineating boundaries within and without the family, and defining rules "so that all members know that this is the way our family is" (p.201). The repetition of the symbolic behavior is believed to reinforce group identity (Steinglass et al, 1987). In general, the underlying hypothesis of the study was supported. Families whose rituals are altered substantially during periods of heavy parental drinking (subsumptive families) are much more likely to transmit alcoholism to their children than are families whose rituals are maintained relatively intact throughout the child's

growing up years, including the times of most severe parental alcoholism (distinctive families) (Wolin et al, 1980). This is especially apparent in whether or not the special activities of holidays (ie. Christmas) are protected from the intrusion of alcohol abuse (p.210). While almost three-fourths of the nontransmitter families kept their holidays intact, only one in six of the transmitter group did so (p.212). Protective features of nontransmitter families include (p.211):

1. The alcoholic parent is not intoxicated at the time of the rituals;
2. Family actively rejects intoxication if it does occur at the time of a ritual;
3. Absence of change in alcoholic's level of participation in ritual life (ie. diminished or extra-involvement);
4. Active rejection of change to alcoholic's level of participation;
5. Absence of overall change in the ritual areas during periods of heaviest parental drinking (ie. cancelling Christmas plans because parent is bingeing).

Overall, there appears to be strong evidence supporting a Family Systems approach to understanding intergenerational transmission of alcoholism. Characteristics of disengagement and enmeshment, as well as problems in adapting to stress are common to the alcoholic family. However, it is suggested that these features alone may not be sufficient to explain differential transmission, and the finding that they are common does not preclude the

suggestion that these characteristics may not be found in all families with an alcoholic member. One explanation to account for greater risk of cross-generational transmission in some families is the underlying identity or definition the family embraces, as indicated by its ritual performance. Families who, despite the presence of an alcoholic parent, continue to actively protect their patterns of symbolic communication (rituals) and do not allow alcohol to become a central organizing 'theme' (alcoholic identity) are predicted to be less likely to transmit alcoholism to subsequent generations.

Psychosocial Consequences

The majority of attempts to characterize the "Children of Alcoholics" (COA's) typical personality traits appear to arise from a problem perspective. Most commonly, these suggestions are based on clinical observations (e.g. Black, Bucky & Wilder-Padilla, 1986; Woititz, 1983, 1990) directed toward counselors or intended for self-help and exploration (e.g. Ackerman, 1983; Deutch, 1982). A relative dearth of empirical evidence and theory is available at present. However, methodological shortcomings such as the lack of a unifying theoretical framework in COA literature (Johnson & Bennett, 1988), absence of controls, and selective sampling with a pathology bias (Porterfield, 1984) make it difficult to compare studies (Wilson & Offord, 1978) and have been

identified as obstacles minimizing the validity of conclusions (Porterfield, 1984).

One theoretical framework offered as explanation for the COA's plight is based on Erikson's (1963) psychosocial development perspective. Beletis and Brown (1981) suggest that the developmental stages of childhood can be impacted by dysfunctional parent-child interactions. At the earliest stage, Trust vs. Mistrust (Erikson, 1963), parental alcoholism may have such a powerful impact that the child's ability to handle later stages, for example the development of identity and intimacy, is greatly undermined (Ackerman, 1987). Brown's (1985) clinical impression that these children experience feelings of uncertainty and fear and fail to develop an autonomous identity appears consistent with an Eriksonian framework.

However, Nardi (1981) suggests that a role-theoretical perspective may best account for the research findings in COA literature. The idea that children with an alcoholic parent typically enact identifiable roles has found acceptance among many clinicians and laypersons. Black (1979) outlines three primary roles taken on by COAs: the responsible one, the adjuster, and the placater. She contends that an all-or-none behavior pattern of misbehaving or overachieving is present. Hecht (1973) echoes this theme of the COAs' bipolar nature, proposing that these children are either rebellious, depressed, impulsive and hostile or

rigid, driven, demanding and moralistic. Wegschieder (1981) further suggests that children in alcoholic families adopt roles as coping mechanisms. The hero, the scapegoat, the lost child, and the family mascot (Wegschieder, 1981; Wegschieder-Cruse, 1986) are proposed as roles characteristic of COAs. However, given that the above conclusions are based exclusively on clinical observations of an unstated number of children in therapy with no control group and as yet unoperationalized variables (Giglio & Kaufman, 1990) proposals regarding COA roles remain tentative at best.

Janet Woititz (1983;1990), an author of numerous self-exploration books written for children of alcoholics, contends that the main problem with current research is that we have not yet "labeled" this population fully (1983, p.3). Based on her meetings with an unstated number of Adult Children of Alcoholics groups, Woititz proposes 13 generalizations which she believes to characterize children who grow up in alcoholic families (see Appendix 1). To summarize, Woititz explains that "a child is very much like a puppy" (1983, p.7; 1990, p.1) that is most importantly carefree; "if a child is like a puppy, you (COAs) were not a child" (1983, p.7; 1990, p.1).

A further attempt to simply list the characteristics of these children is found in Robert Ackerman's book, Children of Alcoholics: A Guide for Parents, Educators and Therapists

(1987, p.103-104). He suggests that a teacher can identify children of alcoholics by the following behavioral indicators:

- Morning tardiness (especially Monday)
- Consistent concern with getting home promptly at the end of the day
- Malodorousness (ie. smelly)
- Improper clothing for the weather
- Avoidance of conflict and arguments
- Friendlessness and isolation
- Frequent illness (especially upset stomach)
- Fatigue
- Hyperactivity
- Exaggerated concern with achievement and satisfying authority.

Subsequent to their identification, Ackerman (1987) suggests that the school can better utilize its resources to help the children achieve more successful skills, attitudes, and values via a Student Assistance Program (p.108).

Janet Woititz and Robert Ackerman are representative of much anecdotal literature available to clinicians and the general public. Group membership is viewed as predictive of a variety of clearly definable dysfunctional behaviors. However, other researchers in the area suggest that the major issue in regard to children of alcoholics is not the lack of a label, it is the way the label is used (Beidler,

1989). The tendency to treat all children of alcoholics as if they fit into a single diagnostic category is not justified, in their opinion. Beidler (1989) contends that, contrary to popular opinion (eg. Black & Brown, 1979; Black et al, 1986), there is not sufficient evidence available to suggest a clearly defined and unique syndrome labeled 'Children of Alcoholics'. Thus, a movement away from the labeling of individuals toward the study of the differential impact of family alcoholism is suggested. Assigning a label without clear meaning has potentially powerful detrimental effects upon the continued development of a fuller understanding of the complex implications of alcoholism.

In empirical studies, children of alcoholics have been found to have poorer self-concepts than children of nonalcoholics. O'Gorman (cited in Russell, Henderson & Blume, 1986) compared 26 adolescents aged twelve to eighteen years from actively alcoholic homes to 23 teens living in a home with a recovered alcoholic parent, and to a third group of 27 adolescents with no family history of alcoholism. The children of both active and recovered alcoholics showed significantly lower self-esteem than children of nonalcoholics on the Piers-Harris scale. Baraga (1978) further reports that total years of parental alcoholism does not significantly contribute to lower self-concept, nor does the parents' total years of sobriety tend to restore poor self-concept in their children.

Children from families in which the parent is actively abusing alcohol also demonstrate a more external locus of control than children living with a recovered alcoholic and children of nonalcoholics on the Norwicki-Stickland and Children's Locus of Control Scale (O'Gorman, cited in Russell et al, 1986). External locus of control, denoting a perceived lack of control over personal outcomes, is noted in recent research to be correlated to low self-esteem and depression (Chow, 1990). Perceived lack of control has been found by other investigators to characterize children of alcoholics when compared to a control group (eg. Kern, Hassett & Collip, 1981).

In a further study examining personality characteristics of children of alcoholics, as reported by the alcoholic parent on the Personality Inventory for Children, several significant findings were reported (Kostyniuk, 1988). Most notable is the prominence of depression, suggesting "the presence of this trait or factor as a central feature of the personality variables of COAs"(p.42). Another interesting finding pertained to the Family Relations scale; the percentage of children of alcoholics scoring in the clinical range surpassed normal statistical expectations tenfold. However, it is contended that although 10 percent of the sample attained scores in the clinical range, 90 percent of the ratings remained within the normal range (e.g. T score<60). This result, in

conjunction with the finding that extreme scores were concentrated on only four of the fourteen PIC scales, supports a cautionary approach to labeling. Children of alcoholics may display fewer personality difficulties than has been suggested in the past.

The results of a study using a multivariate model of adjustment to examine the role of proposed "moderator" variables in the adjustment of children of alcoholics (Clair & Genest, 1987), provide further empirical evidence to the above contention. Conceptualizing parental alcoholism as a form of chronic stress, Clair and Genest (1987) predict that exposure to a stressor in itself is only a limited contributor to an individual's overall reaction and adjustment (Lazarus & Folkman, 1984). Many additional factors are related to the child's adjustment.

The pattern of results regarding the family environment resemble those found by Steinglass et al (1987) and Preli et al (1990); dimensions associated with adjustment include healthy emotional bonding (cohesion), expressiveness, and encouragement of the child's independence (p. 353). Both emotional and informational support are also related to adjustment (p.354), suggesting that social resources may assist in protecting against risks associated with growing up in an alcoholic home. Finally, an analysis of children of alcoholic's coping strategies as compared to a control population may also provide a basis for understanding

intrafamilial transmission of alcoholism. In general, emotion-focused (vs. problem-focused) problem solving, accompanied by the use of more wishful thinking and avoidance strategies (e.g. drinking, smoking) which appear to be modeled after the alcoholic parent's coping patterns, are associated with poorer overall adjustment (p.353).

Rather than the family environment alone, both individual adjustment factors and performance outside the home are important to lifelong adjustment (Vaillant, 1977). It is possible to account for these observations within the framework of psychosocial development theory and adolescence (Seltzer, 1982). Seltzer's work on identity development in adolescents does not deny the importance of early family experience, but rather suggests that other variables are of equal importance to adult adjustment. More specifically, Seltzer proposes a shift away from the nuclear family toward peer interaction and competence at performing tasks outside the home as important contributors to adolescent and subsequent adult identity. Therefore, in considering any relationship between early life experience and future outcomes, the findings of researchers such as Seltzer (1982) and Clair and Genest (1987) must also be considered.

Summary

A review of related literature suggests that there are several risk factors associated with being a child of an alcoholic parent including an increased rate of alcoholism (particularly among sons of alcoholic fathers), and psychological and behavioral problems. However, explanations accounting for these observations are still speculative. Much of the foundation for suggestions regarding psychosocial consequences of parental alcoholism is based on clinical observations, quite often with a pathology bias. The children themselves are rarely approached for their own perspective, and adolescents as a group are rarely addressed in discussions about the impact of parental alcoholism. Overall, methodological shortcomings have been identified by many authors as obstacles minimizing the validity of conclusions. Some researchers further claim that there are several variables, in addition to parental alcoholism, that may contribute to or limit adolescent development.

Based on the literature reviewed, the following general research questions were generated to further explore some of the issues presented:

1. Are adolescent children of alcoholics significantly different from a normative sample of North American adolescents, as reported by their parents and/or as reported by the teens

themselves?

2. Is there a disproportionate number of adolescent children of alcoholics scoring in the clinical range?
3. In what areas of personality are the scores elevated?

CHAPTER III

Method

Sample

Potential participants for the study were identified by contacting 41 AA and AlAnon family group representatives in the Edmonton and Calgary area. Fifteen dyads, each with one parent member of AlAnon and one child between the ages of twelve and seventeen (Mean Age = 14.4), agreed to participate in the research and completed the questionnaires. The sample of adolescents included 8 females and 7 males. All of the teens had at least one parent reported to be alcoholic (100% father; 12.5% both father and mother).

Instrumentation

1) Personality Inventory for Children (PIC)

The PIC is a 600-item forced choice (true-false) scale, intended to measure the functioning of children on twelve clinical scales: achievement, intellectual screening, development, somatic concern, depression, family relations, delinquency, withdrawal, anxiety, psychosis, hyperactivity, and social skills. Seventeen supplemental scales, one general screening scale (adjustment), and three validity scales complete the thirty-three subscales. Comparisons with the MMPI are notable. Achenbach (1981) characterized the PIC as a Junior MMPI. The PIC is to be answered by a respondent, typically a parent, who knows the child well.

Its purpose is described in the manual as providing clinically relevant descriptions of children between the ages of 5 1/2 and 17. Items are written at a fifth grade reading level.

Three test-retest studies are reported in the manual. Length of time between testings range from 2 weeks to just over 3 months. Mean test-retest correlations on the 16 profile scales were .86 (outpatients), .71 (normals), and .89 (normals). Internal consistency estimates range from .62 to .84 on the normal standardization sample. Interparent correlations are also acceptable on the 13 substantive profile scales (12 clinical; 1 general); .69 for the clinic and .57 for the normal groups.

A number of validation studies are reported for the PIC. Tuma (1985) reports that validity data for each scale is acceptable. However, it is suggested that the PIC not be used alone to assess the disturbed child (Tuma, 1985). At present, the PIC is a widely used research and clinical tool (Reynolds, 1985).

2) Basic Personality Inventory (BPI)

The BPI is a 240 item self-report true-false scale (Jackson, 1974), intended for use in psychopathological research and assessment. It is a construct-oriented test, developed by the application of construct measurement methodology (Jackson, 1971). It emphasizes convergent and discriminant validity, substantive generalizability

(Chrisjohn, Jackson & Lanigan, 1984), response style suppression (Reddon, Holden & Jackson, 1983), and in the brief format demonstrates a grade 5 reading level. The twelve substantive scales measure dimensions associated with five factors: antisocial behavior, rebellious attitudes, impulsivity, neurotic tendencies, and depression. Chrisjohn et al (1984) report that across several populations (adult clinical, high school normals, and juvenile delinquents), three factors consistently emerge: psychiatric symptomology, social symptomology, and depression.

A comparison of the BPI to the MMPI in terms of power to discriminate psychological symptoms among a clinical sample (N=109) indicated that the BPI, although substantially shorter, offers a marginally superior level of discriminating performance (Helmes & Barilko, 1988). Evidence of construct validity for the BPI with young offenders (Austin, Leschied, Jaffe & Sas, 1986) and the ability to predict recidivism in this population (Jaffe, Leschied, Sas, Austin & Smiley, 1985) has also been demonstrated. KR-20 reliability coefficients for high school adolescents on the twelve 20-item scales range from .57 (Anxiety) to .80 (Depression) (Reddon, 1984).

Data Collection

Forty-one AA and AlAnon family group representatives were approached in the Calgary and Edmonton area to determine interest in participation. Distribution of

questionnaires was accomplished either by an in-person meeting with groups upon invitation, or by mail-out. Participants received two seperate packages, one for the adolescent and one for the parent. The parent's package contained the information for consent form (see Appendix 2), a demographics questionnaire (Appendix 2), and the Personality Inventory for Children test booklet and response form. The child's package contained an instruction sheet (see Appendix 2) and the Basic Personality Inventory test booklet and answer sheet. An assurance of anonymity, volunteerism, and confidentiality was provided to all participants. Participants were identified by a code number at the top of their appropriate Inventory response sheet. In order to ensure that dyads could be correctly matched, parent and child were assigned the same code number. Participants were instructed to not include their names on the response sheet. Questionnaires were completed independently and returned to the researcher via mail. Of the 86 questionnaires that were distributed, 30 were returned, for a response rate of 35%.

Research Questions

In order to investigate the personality characteristics of adolescent children of alcoholics (COAs) the following research questions were generated:

1. Do COAs score significantly higher or lower than a norm population as reported by their parents on

the PIC and/or as reported by the adolescents themselves on the BPI?

2. Do a disproportionate number of COAs have scores in the clinical range (T>70) when compared to a random sample of the general population?
3. Which BPI and PIC scales were most frequently elevated?
4. What percentage of COAs had one or more scales in the clinical range?

Data Analysis

All returned questionnaires were hand-scored, and frequencies, means and standard deviations calcualted from raw scores. In order to allow for comparison among each test's subscales and between genders, raw scores on the BPI and PIC were converted to T scores. The question of whether there are significant differences between the sample score means and the norm population means was assessed by performing a t-test of independent means (p=.05) on each of the clinical scales for the BPI and PIC. Although T scores have a known standard deviation of 10, a t-test was employed rather than a z-test due to the relatively small sample size (n=15), as is recommended by Borg and Gall (1989).

An analysis of the proportion of COAs scoring in the clinical range (T score>70) on the BPI and PIC was also undertaken. A comparison of the proportion of T scores in the clinical range for COAs to the proportion expected on

the basis of the normal distribution provided information about personality profile differences between the norm population and the research sample. A frequency chart was also constructed displaying subscale scores at specific ranges in order to identify individual responses, group frequencies and clinical ranges.

CHAPTER IV

RESULTS AND DISCUSSION

In this chapter the results of the data analysis will be presented as they relate to the research questions.

Responses to Research Questions

Question 1

1). PIC Results

To determine whether there was a significant difference between the means of COAs and a norm population, a t-test of independent means was run on each of the PIC subscales. The test was performed on T-scores which take into consideration the child's age and gender. Results are presented in Table 1.

Differences between the sample's mean scores and norm group means were significant at the .05 level on all but one of the PIC's clinical scales [ie. Achievement (ACH), Intellectual Screening (IS), Development (DVL), Somatic Concerns (SOM), Depression (D), Family Relations (FAM), Delinquency (DLQ), Withdrawal (WDL), Anxiety (ANX), Psychosis (PSY), and Social Skills (SSK)]. The single exception was the Hyperactivity (HYP) scale where no significant difference was found (t=-.96).

A further consideration pertinent to the interpretation of PIC subscale mean scores was the presence of a great deal of individual variability on several of the PIC subscales,

as indicated on Table 1. With a relatively small sample size (n=15), the potential impact on the mean of extreme individual scores within the sampling distribution is of concern. For example, the Psychosis suscale demonstrated an overall above average mean (Mean=61.56); however, there was also extensive variability among individual respondents (SD=15.37). Scores ranged from T=45 to T=98, with 4/15 of respondents scoring T>70 and fully 11/15 scoring between T=45 and T=55. Thus, the distribution of scores is actually positively skewed. The vast majority of adolescent COAs had scores in the normal range with a few individuals scoring at the extreme.

2). BPI Results

A similar procedure was performed with BPI results as was undetaken on PIC scores, in order to determine whether the means of COAs and a norm population differed significantly on this self-report measure. Again, raw scores were converted to T-scores respective of respondent gender and age (ie. adolescent norms were used). Results are presented in Table 2.

Contrary to the PIC results, differences between the COAs' mean scores and norm group means were significant at the .05 level on only one of the BPI's clinical scales, Depression (D), where $t(14)=2.11$. Two other scales' mean T-scores were also in the high average range, Social Introversion (SoI) and Self-Depreciation (SDp), and were

significant at the .10 level. These scores suggest that the adolescents sampled may tend to have a negative view of themselves, their environment, and their future. The presence of elevated scores on both Depression and Self-Depreciation suggests that "the depression is more chronic than acute" (Jackson, 1989, p.22). When confronted with problems, these individuals tend to have little confidence in their problem-solving ability and often indicate a sense of helplessness. Their reported tendency toward isolation may contribute to an increased vulnerability during stressful periods because of their limited support system.

Table 1

Comparison of PIC Subscale Mean Scores to the Norm

Scale	Mean	SD	t
Achievement	58.92	11.86	2.91*
Intellectual Screening	59.13	16.45	2.15*
Development	58.07	13.83	2.26*
Somatic Concern	58.92	11.26	3.07**
Depression	66.71	12.90	5.02**
Family Relations	66.16	12.78	4.90**
Delinquency	64.27	15.70	3.52**
Withdrawal	65.56	14.27	4.22**
Anxiety	63.92	12.45	4.33**
Psychosis	61.56	15.37	2.91*
Hyperactivity	47.42	10.49	-.96
Social Skills	56.63	11.81	2.17*

df = 14, two-tailed

* $p < .05$

** $p < .01$

Table 2

Comparison of BPI Subscale Mean Scores to the Norms

Scale	Mean	SD	t
Hypochondriasis	51.53	9.85	0.60
Depression	55.40	9.92	2.11*
Denial	48.00	10.40	-.74
Interpersonal Problems	51.00	13.31	0.29
Alienation	48.33	9.96	-.65
Persecutory Ideas	53.13	10.63	1.14
Anxiety	51.87	9.98	0.73
Thinking Disorder	49.33	10.20	-.25
Impulse Expression	49.73	10.67	-.10
Social Introversion	55.00	10.45	1.85
Self Depreciation	54.80	9.65	1.93
Deviation	52.27	12.09	0.73

df = 14, two-tailed

* $p < .05$

Question 2

To determine whether a disproportionate number of the sampled adolescent children of alcoholics scored in the clinical range as compared to the norm adolescent population, a chart of individual scores was constructed for the BPI and PIC independently. Individual profiles were plotted and score frequencies recorded. Two levels of score elevation were delineated. The above average range, termed the critical level, was defined as T-score>60<70 and therefore included scores falling one standard deviation above the mean (T=50). Scores significantly above average, the clinical range, were defined as two standard deviations above the mean, or T>70. On the basis of the expected normal distribution of T-scores in the general population, it was predicted that 14% of sampled COAs would be in the critical range (T>60<70) and 2% of the sample would have scores in the clinical range (T>70).

Table 3 presents the percentages of COAs in the clinical and critical ranges as reported by parents on the PIC. For this sample, there was an overrepresentation on each subscale with the exception of Hyperactivity and the two validity scales, Lie and Defensiveness. On the Depression subscale, the normally expected level was exceeded by 15 times. On Delinquency, Intellectual Screening, Anxiety, Psychosis and Social Skills, clinical level scores occured 10-13 times more often than expected.

As can be seen by Table 4, self-reported clinical level scores on the BPI were somewhat less frequent than the parent-reported scores on the PIC. COAs were overrepresented on eight of the twelve subscales. The expected percentage of scores in the clinical range was significantly exceeded on the Interpersonal Problems subscale at 10 times the expected level. Over 6 times the expected percentage of individuals was also noted on the Depression subscale.

Table 3

Comparison of the Percentage of Elevated PIC T-scores to Expected Percentages in the General Population.

	T-score Range	
	>60<70	>70
Expected	14%	2%
Achievement	26.7%	6.7%
Intellectual Screening	6.7%	20.0%
Development	6.7%	13.3%
Somatic Concern	6.7%	13.3%
Depression	6.7%	30.0%
Family Relations	30.0%	13.3%
Delinquency	20.0%	13.3%
Withdrawal	13.3%	26.7%
Anxiety	20.0%	20.0%
Psychosis	0%	26.7%
Hyperactivity	0%	0%
Social Skills	6.7%	20.0%
Lie	6.7%	0%
Defensiveness	0%	0%

Table 4

Comparison of the Percentage of Elevated BPI T-scores to Expected Percentages in the General Population.

	T-score Ranges	
	>60<70	>70
Expected	14%	2%
Hypochondriasis	26.7%	0%
Depression	26.7%	13.3%
Denial	6.7%	6.7%
Interpersonal Problems	6.7%	20.0%
Alienation	13.3%	0%
Persecutory Ideas	13.3%	6.7%
Anxiety	20.0%	6.7%
Thinking Disorder	26.7%	0%
Impulse Expression	20.0%	0%
Social Introversion	26.7%	6.7%
Self Depreciation	20.0%	6.7%
Deviation	13.3%	6.7%

Question 3

In order to determine which PIC and BPI subscales demonstrated the most frequent elevations the frequency chart of individual scores was again used and the percent of scores in the above average range was calculated. On the PIC, nearly one-half to one-third of respondents demonstrated above average scores (T>60) on 6 subscales: Family Relations (43.3%), Anxiety (40%), Withdrawal (40%), Depression (36.7%), Achievement (33.4%), and Delinquency (33.3%). When only the clinical level (T>70) was considered, high scores occured most frequently on the scales of Depression (30%), Withdrawal (26.7%), Psychosis (26.7%), Anxiety (20%), Social Skills (20%), and Intellectual Screening (20%).

Subscales on the BPI demonstrating the most frequent elevations in the above average range (T>60) were Depression (40%) and Social Introversion (33.4%). It is interesting to note the presence of depression and social introversion/withdrawal among the most frequent scales in the above average range on both the PIC and BPI. At the clinical level (T>70) on the BPI, scales demonstrating the most frequent elevations were Interpersonal Problems (20%) and Depression (13.3%). Although considerably fewer individuals reported clinical levels of depression on the BPI than on the PIC, it remains among the most frequently elevated subscales on both measures.

Question 4

Individual profiles were used in order determine the percentage of COAs with one or more elevated (T>70) scores on the BPI and on the PIC clinical subscales.

As compared to expected levels in the general population, the percentage of adolescent children of alcoholics with one or more scores in the clinical range on the PIC and BPI is higher. Overall, 53.3% of the total PIC sample and 26.7% of the BPI sample had one or more scores in the clinical range. On the surface this result suggests that a significant discrepancy may be present between parent and child perceptions of the severity of problems. However, several of the BPI and PIC subscales are not directly comparable, measuring somewhat different aspects of the individual's functioning. For example, the PIC's Delinquency scale, which accounted for 1/4 of the 53.3% of individuals with scores in the clinical range on this instrument, does not have an equivalent counterpart on the BPI. Thus, any conclusions regarding apparent adolescent-parent discrepancies must be interpretted with utmost caution.

Summary and Discussion

The comparison of adolescent children of alcoholics' mean subscale scores on the PIC and BPI to the general population yielded several interesting and somewhat contradictory results. Mean scores on the PIC subscales tended to be in the high to above average range, with the exception of Hyperactivity. Depression demonstrated the highest overall mean score. However, some caution should be exercised in the interpretation of this result due to extensive variability of individual respondents on many of the PIC subscales. Conversely, on the BPI, mean scores tended to remain in the mid average range ($T>45<55$). However, Depression again demonstrated the highest overall mean. One explanation for the apparent discrepany in the number of subscales reaching significance on the PIC as compared to the BPI may be an artifact of the sampling method. Specifically, parents were all members of self-help groups concerned with alcoholism. The adolescents in this sample were not necessarily attending any alcohol-related group or aware that their parents were doing so. Thus, the trend identified in the present study, of mean subscale scores on the PIC being consistently higher than those found on the BPI, may be associated with the parents' increased awareness of and sensistivity to the potentially negative impact of alcoholism on the psychosocial functioning of their children as a result of their group experience.

In general, COAs also tended to be overrepresented in the clinical range (T>70) as compared to what was expected on the basis of a normally distributed general population. On the PIC, each subscale except Hyperactivity and the two validity scales (Defensiveness and Lie) was found to be greatly overrepresented. On the Depression subscale, the normally expected level was exceeded by 15 times. The BPI also demonstrated a majority of subscales in the clinical range. Of particular note was the Interpersonal Problems and Depression subscales, at 10 times and over 6 times the expected level respectively.

There was further consistency in the results of the PIC and BPI when the frequency of subscale scores in the clinical range was tabulated. On the PIC, clinical level scores most often occured on the scales of Depression, Withdrawal, Psychosis, Anxiety, Social Skills, and Intellectual Screening. At the clinical level on the BPI, scales demonstrating the most frequent elevations were Interpersonal Problems and Depression.

When the above average scores (T>60) were included, elevations on the PIC's Family Relations subscale occured in almost one-half of the sample, making it the most frequently occuring subscale overall. Subscales on the BPI with the most frequent elevations in the above average range were Depression and Social Introversion. Taken together, these results suggest some interesting trends in the psychosocial

functioning of adolescent children of alcoholics. As a group, there is an apparent tendency toward depression, which was identified in the present study by both parents and the teens themselves. Many may withdraw from social contact and have difficulty coping on an interpersonal level, both within their family unit and outside.

An examination of individual profiles found that approximately 53% of the total PIC sample and 27% of the BPI sample had at least one score in the clinical range. Despite the significant discrepancy between PIC and BPI results by this analysis, it was earlier suggested that at least part of the difference may be accounted for by individual elevations on the PIC's Delinquency scale, a behavioral measure with no equivalent counterpart on the BPI. Another potential modifying variable, however, may be related to the aforementioned systematic trend of PIC scores being more elevated than BPI subscale scores, a possible artifact of the sampling method.

Although it has been noted that, as a group, adolescent children of alcoholics in this sample exceeded expected numbers in the clinical range by as much as 15 times, care should be taken in trying to paint a typical picture of COAs. Specifically, despite 53% of the PIC sample and 27% of the BPI sample having at least one score in the clinical range (T>70), the converse is also true; 47% of the PIC sample and fully 73% of adolescents sampled on the BPI did

not evidence a single clinically significant score.

Further implications of the above findings shall be discussed in Chapter V.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of the present descriptive study was to objectively describe the psychosocial functioning of adolescent children of alcoholics from the perspective of parents and the children themselves. This was considered to be an important but as yet relatively unexplored extension of previously documented research in the area of parental alcoholism and personality. Volunteers were solicited from AA and AlAnon family groups and requested to invite their teenage children, between the ages of 12 and 17, to participate as well. The intent was to circumvent, at least with the adolescent sample, one of the most common criticisms of COA literature; that of selective sampling with a pathology bias (Porterfield, 1984). Each parent-child dyad was asked to complete an anonymous mail-back questionnaire, including the Basic Personality Inventory (completed by the teen) and the Personality Inventory for Children (completed by the parent). Group and individual profile data were tabulated in order to address questions of the extent to which the sample diverged from or was consistent with the general adolescent population. Based on the results of the study, the following conclusions were reached:

1. As compared to PIC norms, a statistically significant difference was found on all clinical subscales with the exception of Hyperactivity. In contrast, mean scores on the BPI tended to be substantially lower and reached significance on only one subscale, Depression. Social Introversion and Self-Depreciation were in the high average range.

2. As compared to a random sample in the general population, adolescent COA scores in this sample tended to be overrepresented at the clinical level (T>70). Depression scores on both the PIC and BPI exceeded the normally expected level, by 15 and over 6 times respectively. Clinical level scores occured 10-13 times more often than expected on the PIC's Delinquency, Intellectual Screening, Anxiety, Psychosis and Social Skills subscales and 10 times the expected level on the BPI's Interpersonal Problems scale.

3. On the PIC, clinical level scores most often occured on the Depression(30%), Withdrawal(26.7%), Psychosis(26.7%), Anxiety(20%), Social Skills(20%) and Intellectual Screening(20%) subscales. Interpersonal Problems (20%) and Depression(13.3%) demonstrated the most frequent elevations in the clinical range on the BPI.

4. Overall, approximately 53% of the PIC sample and 27% of the BPI sample had one or more scores in the clinical range.

Discussion

The present study found that the scores of parents sampled on the PIC differed significantly from those of the PIC norm population, suggesting that from a parent's perspective, many of their children may have personality characteristics significantly different from the general population. However, when the teens themselves were asked on the BPI about their psychosocial functioning, their responses as a group tended to be within the average range. It should be remembered, though, that parent participants were all members of self-groups associated with alcoholism whereas the teens in this sample were not necessarily attending any alcohol-related groups which may have introduced some systematic differences in the groups' perceptions of and sensitivity to psychosocial problems. The magnitude of differences found between the groups suggests that the potential impact of self-help group membership on an individual's perception of their psychological functioning may be an interesting topic for investigation. A further question about the consistency of parent and child perceptions is also raised. For example, would there be greater consistency if both parent and child are or are not involved in self-help groups?

A major finding of this study was the consistent presence of depression among elevated scores, suggesting that it may be an important characteristic in the emotional functioning of adolescent children of alcoholics. This finding supports earlier contentions that depression may be a central feature of the personality of COAs (Kostyniuk, 1988). Of further importance to the present research is Chow's (1990) conclusion that depression is associated with low self-esteem and a perceived lack of control. Overall, the results of the current study are consistent with this contention and suggest that the triad identified by Chow may be a potential theme among adolescent COAs. In general, the sample tended to present as depressed, having a negative view of themselves and their future, and socially withdrawn. The perceived lack of control or helplessness demonstrated by the present sample has also been found by other researchers to charaterize children of alcoholics when compared to a control group (Kern, Hassett & Collip, 1981). It follows that a potential avenue for future research may be in further investigating the triad identified by Chow and its occurence among the population of COAs in particular.

There was also a prevalence of elevated scores on the Family Relations subscale on the PIC and Interpersonal Problems on the BPI. This result lends support to researchers who contend that alcoholism is a 'family disease' (Bepko & Krestan, 1985; Preli et al, 1990) that may

be manifested by problems in emotional bonding and individual autonomy (Minuchin, 1974).

Although the role of moderator variables in the adjustment of children of alcoholics was not directly addressed in the present study it is essential that they be stressed in the interpretation of any relationship between life experiences and personal outcomes. Clair and Genest (1987) identified several variables related to the adjustment of COAs, including social resources and problem-solving skills. Among the group of adolescents sampled, there was a tendency to be lacking in both of these areas, suggesting that further research into Clair and Genest's position may be warranted.

Attention must also be drawn to the fact that there was a wide range of individual scores in this sample, supporting Beidler's (1989) contention that COAs are a heterogeneous population. Thus, these results are in sharp contrast to the opinions of many popular writers who would contend that group membership is predictive of a variety of clearly definable dysfunctional behaviors (e.g. Ackerman, 1987; Black et al, 1986; Woititz, 1990). Therefore, although the present study has identified several trends among the personality functioning of adolescent children of alcoholics, individual differences must be stressed and any attempt to identify these individuals via list-type instruments (e.g. Ackerman, 1987) and implement aggressive

intervention strategies globally (ie. special classroom placement) must be carefully evaluated.

Suggestions for Further Research

The results of the present study have raised several questions regarding the psychosocial functioning of adolescent children of alcoholics. To date, conclusions about the personality variables associated with COAs have largely been based upon clinical observation of undefined samples, typically with a pathology bias. Further investigation of this population using objective measures and defined samples is needed to examine popular assumptions. This study has generated several questions that may be investigated in future empirical research including the following:

a) What is the impact of self-help group membership on an individual's perception of his or her psychological functioning?

b) Does the triad (e.g. depression, low self-esteem, and external locus of control) identified by Chow (1990) occur more frequently among adolescent children of alcoholics than it does in the general adolescent population?

c) Is there consistency between parent and adolescent COAs in their perception of the child's

functioning? Is there an interaction between self-help group membership and consistency in perceptions?

d) Do adolescent children of alcoholics with greater social resources and problem-solving skills demonstrate better adjustment than adolescent COAs with fewer resources and skills?

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Appendix 1

PERSONALITY CHARACTERISTICS
(WOITITZ, 1983)

1. ADULT CHILDREN OF ALCOHOLICS GUESS AT WHAT NORMAL IS

2. ADULT CHILDREN OF ALCOHOLICS HAVE DIFFICULTY FOLLOWING A PROJECT THROUGH FROM BEGINNING TO END

3. ADULT CHILDREN OF ALCOHOLICS LIE WHEN IT WOULD BE JUST AS EASY TO TELL THE TRUTH

4. ADULT CHILDREN OF ALCOHOLICS JUDGE THEMSELVES WITHOUT MERCY

5. ADULT CHILDREN OF ALCOHOLICS HAVE DIFFICULTY HAVING FUN

6. ADULT CHILDREN OF ALCOHOLICS TAKE THEMSELVES VERY SERIOUSLY

7. ADULT CHILDREN OF ALCOHOLICS HAVE DIFFICULTY WITH INTIMATE RELATIONSHIPS

8. ADULT CHILDREN OF ALCOHOLICS OVERREACT TO CHANGES OVER WHICH THEY HAVE NO CONTROL

9. ADULT CHILDREN OF ALCOHOLICS CONSTANTLY SEEK APPROVAL AND AFFIRMATION

10. ADULT CHILDREN OF ALCOHOLICS USUALLY FEEL THAT THEY ARE DIFFERENT FROM OTHER PEOPLE

11. ADULT CHILDREN OF ALCOHOLICS ARE SUPER RESPONSIBLE OR SUPER IRRESPONSIBLE

12. ADULT CHILDREN OF ALCOHOLICS ARE EXTREMELY LOYAL, EVEN IN THE FACE OF EVIDENCE THAT LOYALTY IS UNDESERVED

13. ADULT CHILDREN OF ALCOHOLICS ARE IMPULSIVE. THIS LEADS TO CONFUSION, SELF-LOATHING, AND LOSS OF CONTROL OVER THEIR ENVIRONMENT

Appendix 2

Information for Consent

Dear Parent/Guardian,

My name is Sherry Greenbank and I am presently enrolled in my thesis year of the Masters of Educational Psychology in the area of counseling at the University of Alberta. My research focus is children of alcoholics and I am currently beginning a study in which I hope to discover whether there are any common personality factors among these children. I believe that the results from this study may be very helpful for counselors working with families of alcoholics, and especially children.

Many researchers and authors have tried to describe and write about children with an alcoholic parent, but very few have asked for a parent's viewpoint or directly asked the children to describe themselves. This study needs the participation of a number of parents/guardians and children. Therefore, if you are a parent or guardian of a child between the ages of 12 and 17, I would like to ask you to consider being a member of this study.

In this study you and your teenager will each be asked to complete a questionnaire about how the child is getting along in day to day life. The questions range from the child's social relationships to his/her physical health. These questionnaires should take about one hour to complete and can be filled out in your own home. You will <u>not</u> be asked to give your names or phone number. Your answers to the questions will be destroyed when the study is finished, in the winter of 1992. At any time throughout the study you may withdraw your consent and terminate your participation in this study. Thank you for your help. Please feel free to call me at home if you have any questions or concerns at 963-9361.

Thank you again,

Sherry Greenbank

Appendix 2 cont'd

INSTRUCTIONS

Thank you for agreeing to participate in this study. Your comments and responses to the enclosed test and questionnaire will be completely confidential. All participants have been given a code number that will be used by the researcher to identify parent and child pairs. Your code number is found on the front of the enclosed questionnaire answer sheet. Please use this number if you wish to discuss your test results with the researcher, Sherry Greenbank.

Directions for completing the test are written in the test booklet. It is best to use a pencil when filling in the answer sheet. Do not write your name at the top of this sheet. Choose the answer that you believe best describes yourself at this time. Choose only one answer for each question, making sure not to skip any questions. The questions usually take about one hour to complete. When you have finished, please place all questionnaires and answer sheets in the envelope provided and seal it. If you have questions or concerns about this questionnaire or the study, please contact me at 963-9361.

Sherry Greenbank

Appendix 2 cont'd

QUESTIONNAIRE

This questionnaire is intended to be completed by the parent or caregiver of a child between the ages of 12 and 17. Please read each question carefully before answering. Your answers will be confidential and you will not be asked to identify yourself.

1. Age of child at the time of testing? _____

2. Child's gender (please circle): male female

3. How long have you known this child? _____

4. Which of the child's parents are identified as alcoholic?

   father only ____

   mother only ____

   both father and mother ____

5. What is your relationship to this child?

   father ____

   mother ____

   caregiver (please describe) _____